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Rx Medicaid Pharmacy Reimbursements

Summary of the Oversight Hearing of the
Joint Committee on Health Care
August 27, 2002
State House, Boston

Summary and Recommendations
Prepared by Senator Richard T. Moore

September 3, 2002

Table of Contents

Introduction 3
- Overview
- Background

Budget Proposals 5
- User fee
- Wholesale Acquisition Cost
- Co-payments

Summary of Hearing 9
- Overview
- Chairman's Message
- Hearing Invitees
- Testimony

Senator Moore's Recommendations 14
- Pharmacy Medicaid Reimbursement Rate
- Medicaid Co-payment
- Non-Medicaid Prescription User Fee (Tax)
- Access to Prescription Drugs
- Variations in Impact on Pharmacy Types
- Medical Errors

Conclusion 21
- Recommendation Summary
- Closing Statement

Introduction

▪ Overview

According the 2002 Pharmaceuticals Guide by the National Conference of State Legislatures (NCSL), as of February 2002, twenty-five states have higher percentage of total Medicaid dollars spent on prescription drugs than Massachusetts. Furthermore, the U.S. average is 10.8 percent so Massachusetts' costs are 0.7 percent higher than the national average. In essence, these statistics mean that Massachusetts is in the fiftieth percentile with regard to drug costs.

The 2002 Pharmaceuticals Guide also notes that, in 1998, the United States average prescription drug expense per Medicaid recipient was $363. Massachusetts spent on average $811 for prescription drugs per Medicaid recipient in 1998. Fourteen other states, however, spent more per recipient than Massachusetts, while thirty-four states spent less per recipient than Massachusetts. These 1998 figures are the latest available state fiscal comparisons and the NCSL guide is based on information from the Centers for Medicare and Medicaid Services and the National Pharmaceutical Council.

While Massachusetts Medicaid overall prescription drug expenses are generally in line with the national average, the increasing costs of drugs to the Medicaid program has raised serious concern at a time when state revenues require every effort to be made to find cost savings in the budget. Consequently, the Legislature, in developing the FY '03 state budget sought areas where reduction in expenditures might be possible in the funding of the state's Medicaid program.

▪ Background

In August 2001, the Federal Department of Health and Human Services Office of the Inspector General (OIG) issued a study entitled "Medicaid Pharmacy - Actual Acquisition Cost of Brand Name Prescription Drug Products". This report provided the results of the OIG's review of pharmacy acquisition costs for brand name drugs reimbursed under the Medicaid Prescription drug program. In sum, the report concluded that the Medicaid program could save as much at $1 billion if the reimbursement was based on a 21.84 percent average discount below the actual acquisition cost. Thus, the OIG recommended that the Centers for Medicare and Medicaid Services urge the States to bring pharmacy reimbursement more in line with this formula.

Subsequently, the National Community Pharmacists Association and the National Association of Chain Drug Stores requested that the health services researchers at The Center for Pharmacoeconomic Studies at the University of Texas at Austin review the OIG study design, methodology and findings. This subsequent study concluded that States should use caution in relying on the OIG report because of issues relating to methodology and extrapolation of national estimates based on potentially unrepresentative sample of pharmacies and invoices.

In the interim, the Division of Medical Assistance tried to contain rising drug costs. In 1995, pharmacy spending was 9.9 percent of total program expenditures. In 2002, pharmacy spending was 19.2 percent of total program expenditures. Between 1997 and 2000, the Division of Medical Assistance experienced a 17 percent growth in drug costs while nationally spending on prescription drugs grew at an average of 18 percent in the same three year period.

In relying on this report and the statistics from the Division of Medical Assistance, in April 2002, the House Budget proposed three changes to the pharmacy reimbursement policy at the Division of Medical Assistance. The House Budget imposed a pharmacy user fee, reduced the wholesale acquisition cost formula used by the Division of Medical Assistance and imposed higher Medicaid co-payments. The Senate Budget followed suit just two months later, although with some differences in specific details. One specific detail was the amendment by Senator Moore to require a hearing on the changes to the Wholesale Acquisition Cost. A compromise plan that incorporated the hearing, was included in the Conference Committee Report, enacted by the Legislature on July 19, 2002 and signed by the Governor on July 29, 2002. On July 30, several leading state pharmacy chains indicated their intention to withdraw from state Medicaid program as a result of the state budget provisions. On July 31, Senator Richard Moore and Senator Mark Montigny filed legislation that would require a more extensive hearing on the Wholesale Acquisition Cost, the increased co-payments and the pharmacy user fee and would require temporary moratorium on the implementation of the new Wholesale Acquisition Cost. The Senate enacted the bill and sent it to the House. The House did not take up the bill and the session ended in the early hours of August 1.

On August 1, the Boston Globe and the Boston Herald reported that Governor Jane Swift was meeting with the leading chains to encourage them to reconsider their decision to withdraw from Medicaid. At the end of that day, all parties reached an agreement under which the chains would continue to fill Medicaid prescriptions and in which the state would not implement the new rate until October 2, pending a hearing. The hearing was scheduled for September 5, 2002. The hearing would only focus on the Wholesale Acquisition Cost adjustment and not the two other pharmacy-related provisions in the budget. Thus, the Joint Committee on Health Care organized a hearing for August 27, 2002 that would review all three pharmacy-provisions.

Budget Proposals

▪ User Fee

Approximately fifteen states have developed some sort of provider tax or user fee for certain health care providers as a way to generate more federal Medicaid matching dollars. Locally, New York, Vermont and Rhode Island have implemented some form of a user fee. User fees are authorized under the Medicaid Voluntary Contribution and Provider-Specific Tax Amendment of 1991, but four requirements must be met in order for a user fee to be valid.

First, the user fee must be broad based, meaning that it must be imposed on all providers within the same class. Second, the fee must be applied at a uniform rate, meaning that the rate must be the same of all providers within the same class. Third, all fees cannot generate more than twenty-five percent of the total non-federal share of the Medicaid program expenditures for all health care providers in a certain fiscal year. Thus the state must calculate a rate that would raise no more than approximately six hundred and twenty million dollars. Lastly, there cannot be a direct or indirect hold-harmless provision that guarantees repayment of the tax to providers in their Medicaid payment rates.

The House and Senate Budgets created a pharmacy user fee, which would assess a tax on all non-Medicaid and all non-Medicare prescriptions. The pharmacies would pay this assessment to the Division of Medical Assistance. The budgets estimate that this would generate $18 million with another $18 million generated from the federal matching fund program. According the budget language, this $36 million dollars would be used to improve pharmacy reimbursement rates, but pharmacists disagree that they will see any improvement. Only three other states impose a pharmacy tax and in those states, the tax is limited to around 10 cents.

Opponents are fearful that pharmacists will pass this tax to consumers, but under most third party contracts, pharmacists are not allowed to charge any additional costs on a prescription other than the co-payment. In practice, that means the pharmacist will not be able to assess a fee on non-Medicaid prescriptions in the near future as prescribed in the budget language. The pharmacist can charge an assessment fee on non-Medicare prescriptions (e.g. Medicaid prescriptions). However, under federal law, the pharmacist must provide the service regardless of ability to pay. Thus, if the MassHealth member cannot pay the assessment, the pharmacist cannot collect the assessment. Therefore, if the pharmacist cannot collect assessment on "private" payer prescriptions and may not be able to collect the assessment on Medicaid prescriptions, the pharmacist may be liable for having to pay the assessment out of its own pocket.

The Conference Committee did include the implementation of the pharmacy user fee, and included a study by the Division of Health Care Finance and Policy on the impact of the pharmacy user fee program. Pursuant to the Conference Committee Report language, the Division of Health Care Finance and Policy is to consult with the Division of Medical Assistance and the pharmacy industry in conducting its study. Some things the Division of Health Care Finance and Policy must review are whether the fees are passed on to consumers and the long term need for such fees. The Acting Governor, however, vetoed this study.

According to the National Conference of State Legislatures (NCSL), at least three other states have a tax on prescription transactions. Alabama has a ten-cent per prescription tax on prescriptions over three dollars. Kentucky has a fifteen-cent tax on prescriptions and Louisiana has a ten-cent tax. Other states have broader definitions, which may include a tax on prescription transactions. For example, Washington has a 2% tax on HMO gross receipts, which could include prescription transactions. Only twenty-three states have some sort of a broad health care tax. Thus only fifty percent of all states have a health care related tax with only three of the 25 having a prescription tax.

▪ Wholesale Acquisition Cost

The Joint Committee on Health Care encouraged the pharmacy industry to clarify the different formulas used by states to reimburse pharmacies. The two formulas are the Wholesale Acquisition Cost and the Average Wholesale Price. The Wholesale Acquisition Cost is the price charged by the manufacturer to wholesaler to purchase a drug. The Average Wholesale Price is the price that the manufacturer suggests the wholesaler sells the drug to pharmacies. Different purchasers obtain different discounts off the average wholesale price to purchase drugs, but the basis for most third party reimbursements is the discount from the AWP, although some use WAC plus a percentage.

Currently, the Division of Medical Assistance (DMA) reimburses a pharmacist for the cost of a prescription drug for a MassHealth member based on the wholesale acquisition cost (WAC). DMA reimburses the pharmacist the wholesale acquisition cost for that prescription drug plus 10 percent for overhead costs. Massachusetts is one of five states that use this reimbursement formula. In the House budget, the language changed the estimated acquisition cost from WAC plus 10 percent to WAC minus 20 percent for generic drugs and WAC only for brand name drugs. The Senate budget language changed the estimated acquisition cost from WAC plus 10 percent to WAC plus 2 percent for generic and brand name drugs. Needless to say, pharmacists were not happy with either proposal.

The Conference Committee Report changed the estimated acquisition cost from WAC plus 10 percent to WAC minus 2 percent for brand name and generic drugs, exempted long term care pharmacies from the WAC changes, and included language contained in the Senate Budget that requires the Commissioner of the Division of Medical Assistance to hold a hearing on whether the wholesale acquisition cost is adequate to provide payment for pharmacy services; whether the wholesale acquisition cost is sufficient to enlist enough pharmacy providers; and whether it compromises access to pharmacy services for covered patients. The language did not specifically require the Commissioner to hold this hearing before the implementation of the new rate, nor is there a timeline for having the hearing once the budget is enacted.

The Acting Governor did not veto the changes to the estimated acquisition cost nor did she veto the hearing language. However, the Acting Governor did veto the exclusion of long-term care pharmacies from the impact of the estimated acquisition cost adjustment. In addition, the Acting Governor did enter into an agreement with the pharmacies to hold the hearing before the implementation of the new rate and the pharmacy industry agreed not to take action until the hearing and to give notice 30 days before withdrawing from the Medicaid network.

According to the Pharmaceutical Benefits 2002 guide, only Massachusetts and Rhode Island use only the Wholesale Acquisition Cost (WAC) formula. Forty other states use only the Average Wholesale Price (AWP). Seven states use either WAC or the AWP. Only Arizona had not reported. Of the states that have a combination of WAC or AWP, some charge a different rate for chain drug stores than for all other pharmacies or charge one rate for injectables versus other kinds of drugs or take the lowest of WAC or AWP.

The Centers for Medicare and Medicaid Services within the U. S. Department of Health and Human Services has advised the Committee that the definition of Average Wholesale Price or Wholesale Acquisition Cost are somewhat vague. The expectation is that overhead costs of the pharmacies – such as transportation of the product, storage, wages and benefits, taxes, etc. and a reasonable profit – should be accommodated in either the reimbursement rate or the dispensing fee. The dispensing fee in Massachusetts has remained at $3.00 per prescription for ten years (a reduction from an earlier rate of $4.00), and overhead costs for doing business have increased in pharmacies, as in most other areas of the economy. Therefore, the difference between the actual dispensing costs (estimated by pharmacies ranging from $7.56 to $11.36 depending on type of pharmacy) and the rate paid by the state has presumably been part of the reimbursement rate. In many states, this difference is normally included along with other overhead costs in the dispensing fee. Therefore, pharmacies are unhappy that reimbursement rates have been decreased to 2% below the invoice price of the drugs without a corresponding increase in dispensing fees. The pharmacies suggest that they would be loosing money on both the reimbursement rate and the dispensing fee.

The federal Centers for Medicare and Medicaid Services does, in fact, receive all of the corporate data on drug prices from pharmacies across the country but is prohibited from making that information public. Only a few CMS staff actually are permitted access to this data because of the confidentiality requirements. Pharmacies have told the Committee that, in many cases, they are bound by contractual requirements with drug manufacturers from releasing their actual costs, usually related to the costs of generic drugs. The reason for the requirement is that manufacturers do not want other customers to know if particular customers are getting a better break based on volume or formulary limitations. This generally is not the case with brand name drugs, except perhaps older versions of a brand, since companies that manufacture single source brand drugs have a monopoly on the drug and do not offer discounts to any retailer.

▪ Medicaid co-payments

Another intended cost savings for the Medicaid Program is the plan in both budget proposals for Medicaid beneficiaries to pay an increase of MassHealth co-payments, including those for prescription drugs. The current co-payments are fifty cents, but the budgets proposed an increase to one dollar for common office visits, two dollars for prescription drugs and three dollars for emergency room visits. Providers are also impacted by the increase in MassHealth co-payments. Providers are affected because when the Division of Medical Assistance is calculating the rate, it takes into account the co-payment. If, for example, the cost of fully reimbursing the health care provider is fifty dollars, DMA would then subtract the co-payment (i.e. two dollars) from the reimbursement rate and only pay the provider forty-eight dollars. It is up to the provider to collect the remaining two dollars from the patient. Yet, under federal law, the health care provider must provide the service regardless of ability to

pay. Thus, if the MassHealth member cannot pay, the provider loses money. The Conference Committee did maintain the Medicaid co-payment increases and the Acting Governor did not veto the increases.

There is no federal requirement for states to charge a co-payment. The Pharmaceutical Benefits 2001 guide reports that seventeen states do not charge a co-payment or charge no more than a 50-cent co-pay for services under Medicaid. Thirteen states charge only $1 for all Medicaid services and the remaining 20 states (now including Massachusetts) charge a co-payment between $1 and $3. Thus approximately sixty percent of all states have a co-payment of one dollar or less for Medicaid pharmacy and patient co-payments. Furthermore, at least four states charge a different co-payment for generic prescription than brand name prescriptions.

Summary of Hearing

▪ Overview

The oversight hearing took place on August 27, 2002 at 10:00 a.m. at the Massachusetts State House. Committee Chairs, Senator Richard T. Moore and Representative Harriett L. Stanley were in attendance as well as Senators Harriette L. Chandler, Susan Fargo, and Bruce Tarr, and Representatives Peter Koutoujian, Christine Canavan, Carol Cleven, and Shirley Gomes.

Before the hearing, all invitees received the following questions in order to frame their testimony. The questions were as follows:

1. Whether the proposed estimated acquisition cost required by item 4100-0060 of section 2 of the GAA for fiscal year 2003 is adequate to provide payment for pharmacy services that is consistent with efficiency, economy, and quality of care;
2. Whether such proposed estimated acquisition cost is sufficient to enlist enough pharmacy providers so that pharmacy services are available to program recipients statewide and in each county at least to the same extent, as those services are available to the general population of Massachusetts, and whether such estimated acquisition cost compromises the access to pharmacy services for covered patients;
3. Whether the increase of the Medicaid pharmacy co-payment authorized by the GAA for fiscal year 2003 will increase the number of Medicaid recipients who cannot pay the co-payment or will impact access to pharmacy services for covered patients;
4. The effect of the pharmacy user fee authorized by the GAA for fiscal year 2003 on pharmacies and consumers;
5. The adequacy of information available to state legislators, state regulators, and consumers about the wholesale acquisition costs pharmacies pay for prescription drugs; and
6. The ability of the Commonwealth to achieve savings in its pharmacy programs by means unrelated to pharmacy reimbursement. This would include (but not be limited to) purchasing and negotiation strategies to reduce the cost of prescription drugs purchased by or for state programs.

▪ Chairman Moore's Opening Remarks

At the beginning of the hearing, Senate Chair Richard Moore gave a brief statement, which was as follows:

"In accordance with the provisions of Rule 1 of the Joint Rules of the Senate and House of Representatives, the Committee on Health Care has convened this Oversight Hearing relative to the implementation of certain provisions contained in the General Appropriations Act for fiscal year 2003 relative to:

- The reimbursement rate for pharmacies for Medicaid prescription drugs. This rate has been the Wholesale Acquisition Cost plus 10 percent for overhead. Under the budget act, the new rate would be based on Wholesale Acquisition cost minus 2 percent for an estimated savings of $60 million dollars a year.

- The Medicaid co-pay amount. This co-pay has been at the rate of fifty cents per prescription. Under the budget act, the new co-pay is set at $2.00 per prescription.
- A non-Medicaid, non-Medicare prescription user fee. There has been no fee in the past. The new fee, according to budget analysts would be about sixty cents per prescription.

Shortly after the Governor signed the budget act, including the previously stated changes, major pharmacy providers - CVS, Brooks, Walgreen, Stop & Shop and Wal-Mart - all indicated that they would no longer participate in the Massachusetts Medicaid Program citing these three provisions of the budget act. If these plans were implemented by the pharmacies and by independent pharmacies, and in the absence of any other procedure for dispensing Medicaid prescription medications, the ability of Medicaid recipients to obtain prescription medication would be seriously curtailed. This could result in life-threatening conditions for some, and seriously impaired quality of life for others.

The Governor and the pharmacies are to be applauded for agreeing to a moratorium on this issue, and for directing the Division of Health Care Finance and Policy to hold a hearing scheduled for September 5th. It is understood that the Administration's hearing will focus on the issue of the pharmacy reimbursement rate, however we believe that all three issues - reimbursement rate, co-pay increase, and new user fee or tax on non-Medicaid prescription drugs needs to be fully examined to insure that the Legislature had adequate information to support the rationale for enactment of these three changes.

Furthermore, the Committee has been advised that the formula on which the revised Medicaid prescription reimbursement rate, and the rates used by other states, has been called into question as to whether it presents a fair and accurate method for determining a reimbursement rate that is fair to pharmacies, to consumers and to the taxpayers of the Commonwealth. We are interested in learning how we can set a fee that encourages pharmacies to seek the best prices from pharmaceutical manufacturers and wholesalers so that savings can be shared by consumers and taxpayers while, at the same time, continuing to encourage pharmacies to serve our Medicaid clients by recognizing reasonable costs, dispensing fees, and overhead.

We also need to have a better understanding of how Massachusetts compares to other states with regard to reimbursement rates, co-pay, and user fee.

Finally, we are concerned with the increases in the cost of prescription drugs and are anxious to find ways to provide access to these important medications in the most cost-effective manner. If the changes to pharmacy rates enacted in the budget are not the answer, or if these changes need to be modified producing less of a savings, we need to learn if there are other steps that Massachusetts can take to find savings in the cost of prescription drugs that will ease the burden on the state budget.

We thank those who have agreed to present testimony today and those who have provided written information to the Committee.

It is the intention of the chair to provide a report on the findings of this Oversight hearing to our legislative colleagues and to the Administration's hearing on September 5. In addition, the Committee may consider - as provided by the Joint Rules - to make legislative recommendations to the General Court."

▪ Hearing Invitees

The following organizations and individuals testified at the Joint Committee on Health Care pharmacy oversight hearing: Steve Grossman, Massachusetts Pharmacists Association; Alana Arnold, President, Massachusetts Society of Health System Pharmacists; Lawrence Kocot, Senior VP & General Counsel, National Association of Chain Drug Stores; C. Daniel Haron, Vice President, Pharmacy and Professional Affairs, Brooks Pharmacy; Phil Burgess, National Director, Pharmacy Affairs, Walgreen Co.; Carlos Ortiz, Vice President, Government Affairs, CVS Corporation; Alison Staton, Director, Health Care For All; Adaora Ukomah, MassHealth member; George A. Cayer, Chairman of the Mass. Chapter of the LTCPA; Bill Donatelli, President, Mass. Chapter of the American Consulting Pharmacists Association; Patrick Downing, President, McClelland Health Systems; Robert Gittens, Secretary, Executive Office of Health and Human Services; Wendy Warring, Commissioner, Division of Medical Assistance; Todd Brown, Massachusetts Independent Pharmacists Association; Kevin Mulvey, General Counsel, Retailers Association; Dennis Conlin, Owner, Conlin's Drug Store; Don Putney, Independent Pharmacist, North Reading.

▪ Testimony

The Joint Committee on Health Care heard testimony from three main groups: the pharmacies, the state officials, and the health care activists. Below, the testimony is summarized and segregated by organization type. Original copies of the written testimony are available from the Joint Committee on Health Care in Room 130 at the Massachusetts State House, Boston, Massachusetts.

Summary of Pharmacy Testimony

A panel representing the National Association of Chain Drug Stores, CVS, Brooks and Walgreens testified that pharmacies would lose more than $5 per prescription and more than $100 million annually if the state goes through with a proposal to cut Medicaid reimbursement rates. "We want to be part of the solution," said Phil Burgess, national director of pharmacy affairs for Walgreens. "But our concern is that we cannot do that and operate at a loss."

CVS, Walgreens and Brooks, who fill more than 60 percent of the state's Medicaid prescriptions, threatened to withdraw from the program in late July because of the Legislature's decision to cut the state's reimbursement rate to pharmacies for Medicaid prescriptions by 11 percent. The answer, the pharmacies' representatives told the lawmakers, should focus on steering patients toward less expensive generic drugs, rather than brand names, which currently make up 84 percent of the Medicaid prescriptions. "Squeezing pharmacies isn't going to save the government money in this case," said S. Lawrence Kocot, senior vice president of the National Association of Chain Drug Stores. "It's only going to harm beneficiaries."

The pharmacy chains began the debate Tuesday with a two-hour presentation focused on their low profit margin and the need to find other ways to save money on the state's spiraling Medicaid prescription costs. While the drug manufacturing industry posted an 18.5 percent profit in 2001, the pharmacies made only 1.6 percent, according to the presentation.

The average cost of a Medicaid prescription in Massachusetts is $53.60, the drug store representatives said. Of that, 78 percent covers the cost of purchasing the drug from the manufacturer or wholesaler, 19 percent covers pharmacy operational costs, and 1 percent covers the pharmacies' tax and interest payments. That leaves only 2 percent or $1.07 as profit on the average prescription, drug store representatives said. "There's a lot of work that could be done in educating physicians to utilize generic prescriptions more than they do," said Carlos Ortiz, vice president of government affairs for CVS, the state's largest drug store chain.

Currently the state pays pharmacies 10 percent more than what it estimates the wholesalers pay for the drug. Under the proposed cut, pharmacies would get 2 percent less than the wholesalers' estimated cost. In addition, they would continue to get the current $3-per-prescription dispensing fee, however, all types of pharmacies testifying stated that the fee is too low and needs to be closer to the $7.56 to 11.37 that dispensing costs.

The amount patients must co-pay for each prescription would rise to $2 from 50 cents. Pharmacists claim they would have to absorb most of that cost because, under state regulations, they cannot force Medicaid recipients to cover the co-pay. Pharmacy leaders said yesterday that the state should look to other cost-cutting measures, such as using more generic drugs. In Massachusetts, 46 percent of the drugs prescribed are generic, compared with 49 percent on average nationally, pharmacy leaders said. Increasing it by just 1 percent could bring significant savings. ``Squeezing pharmacies isn't going to save the government money in this case," said S. Lawrence Kocot, senior vice president of the National Association of Chain Drug Stores. ``It's only going to harm beneficiaries."

Summary of Administration Response

Health and Human Services Secretary Robert Gittens and Division of Medical Assistance Commissioner Wendy Waring cautioned the Legislature to avoid a game of chicken with the pharmacies and said for the first time that the Massachusetts Medicaid program could survive if the companies followed through on its threat. Commissioner Waring testified that there would still be sufficient pharmacies to maintain access and that the state could use mail order pharmacies to fill any gaps. "We should not engage in a game of brinkmanship," said Wendy Warring, commissioner of the Division of Medical Assistance. "This can't be a negotiated discussion. This has to be a based on data and actual cost."

State regulators said yesterday that even if the chain drugstores quit the program, there are independent stores that might be able to replace them. Many independent stores, however, have said they can't survive under the proposed rate. What's driving the cost higher for Massachusetts and other states, according to industry officials, is the increased use of drugs, doctors who prescribe higher cost brand drugs, and inflation.

Secretary Gittens testified that Health and Human Services is trying to strike a delicate balance between managing the cost of prescription drugs and making sure that the program is lucrative enough that pharmacies will participate in it. This summer's standoff, he told the Committee, "put in stark relief the difficulty of reaching the right balance." He was referring to threats by the chains to withdraw from the program in early August. However, acting Gov. Jane Swift, in accordance with provisions directed by the Legislature, set a public hearing for September 5, 2002 by the Division of Health Care Finance and Policy to gain

further information to determine whether the budget provisions needed any adjustment. She also agreed to freeze the reimbursement rate at its current level until Oct. 2. At that time, a new rate will be announced, which will be retroactively applied to all prescriptions filled after Aug. 1. The federal Centers for Medicare and Medicaid Services agrees that this rate can be, under federal interpretations of the rules, applied in such a retroactive nature.

Both Secretary Gittens and Commissioner Warring stated that, to arrive at a fair reimbursement, the pharmacies will have to open their books for a thorough inspection. The pharmacies should be more forthcoming with their actual costs, say state officials. ``No one wants pharmacies to drop out of this program. We have an obligation to provide access," Commissioner Warring testified. ``On the other hand, we have an obligation to pay no more than (pharmacies') costs, and we have to determine if those costs are reasonable. That's hard to do if they won't give us information." Two controversial reports indicate that states are overpaying pharmacies for Medicaid prescriptions. More information is needed from the pharmacies to determine whether the price is too high, Warring said.

Summary of Testimony of Health Care Activists

Health care activists who have been discussing the issue with pharmacists suggested that the rate be dropped to 5 percent above the estimated wholesaler's price because Rhode Island and Maine use this formula.[1] Allison M. Staton, a spokeswoman for Health Care for All testified at the hearing. Health Care for All condemned the threat by pharmacies to cease serving Medicaid clients, however she thought some action might be needed to ease the problem that the new rates would cause pharmacies. "Given the current economy, all providers are going to have to take some hit."

[1] The National Association of Chain Drug Stores indicates that while they do business in Maine and Rhode Island with a WAC +5 equivalent, this rate does not take into account the higher real estate costs in Massachusetts.

Senator Moore's Recommendations

As a result of over five hours of oral testimony and several written submissions, Senator Richard T. Moore, Senate Chair of the Joint Committee on Health Care has developed the following conclusions and recommendation in six relevant subject areas: pharmacy reimbursement rate, co-payments, user fees, pharmacy access, variation in pharmacy type and medical errors. As the result of these conclusions, the Senator Moore makes nine recommendations in those issue areas.

▪ Pharmacy Medicaid Reimbursement Rate

The selection of a Medicaid Reimbursement rate based on Wholesale Acquisition Cost minus two percent (WAC - 2), enacted by the Legislature and signed into law by Governor Swift, was based on an August 1, 2001 report by the Office of Inspector General (OIG) of the U. S. Department of Health and Human Services. The OIG report suggested that state Medicaid reimbursements for prescription drugs based in existing formulas was too generous and that states should review these rates in an effort to control the rising costs of the Medicaid program for both states and the Federal government. However, the National Association of Chain Drug Stores questioned the validity of the federal formula, and commissioned the Center for Pharmacoeconomic Studies of the University of Texas at Austin to analyze the OIG report.

The University of Texas analysis of the OIG report identified "significant limitations to the study methodology that should be considered by health policy decision-makers when interpreting the findings and implications of the (OIG) study." The analysis cited the following limitations"

1. Non-representative sample strata
2. No correction for non-respondents
3. Non-representative pharmacy invoice sample
4. Inappropriate extrapolation from limited sample to nationwide estimate
5. Inconsistent categorization of brand vs. generic products
6. Discounts not weighted by sales
7. Not all drugs paid for at AWP rate
8. Misleading presentation of estimation variance

The analysis states: "We believe that the OIG's initiatives to determine the appropriateness of Medicaid pharmacy reimbursement rates are worthy goals. However, we suggest that states exercise caution in relying on this report because of several significant issues relating to methodology and extrapolation of national estimates based on what appears to be an unrepresentative sample of pharmacies and invoices."

"Given the limitations noted above, states may want to conduct their own studies of pharmacy's acquisition costs to more accurately determine the pharmacy's costs of purchasing, managing, and distributing an inventory of pharmaceuticals within each state. In addition, we would encourage a parallel study that investigates the appropriateness of current pharmacist "dispensing fee" payments for professional

services to Medicaid recipients." No testimony was provided that Massachusetts Medicaid has any immediate plans to revise the "dispensing fee" from the current $3.00 rate while, at the same time, reducing the reimbursement to two percent below the cost pharmacies pay to acquire the products.

> **RECOMMENDATION #1: The Medicaid Pharmacy Reimbursement Rate should remain frozen at FY '02 rates until the federal government completes its review and reassessment of its report on pharmacy acquisition costs of prescription drugs. Upon release of the revised OIG report, the Swift Administration should establish a new pharmacy reimbursement rate for Medicaid prescriptions.**

> **RECOMMENDATION #2: The Swift Administration, with support from Legislative Leaders, should directly, and through intervention of the Massachusetts Congressional Delegation, seek immediate release of the final OIG report. (Note: Senator Moore has personally issued a written appeal to the OIG for release of the final report, and has written to the Massachusetts delegation seeking assistance in this matter.)**

Testimony provided to the Committee on Health Care suggested that the dispensing costs for chain pharmacies is $7.76 compared to the National Average of $7.26, and that Medicaid prescriptions tend to cost more than the average. The independent pharmacies reported that their dispensing costs average $11.37. It was noted that Massachusetts has not increased its dispensing fee for, perhaps, twenty years; even though the cost of doing business has increased markedly.

If, as indicated by testimony at the hearing, the reimbursement rate would now be set at two percent below the wholesale acquisition cost, the current $3.00 "dispensing fee" would appear to be inadequate to cover the usual and customary costs of doing business with Medicaid clients.

> **RECOMMENDATION #3: Massachusetts should obtain accurate data to determine and establish a reasonable dispensing fee for Medicaid prescriptions.** Every effort should be made to prevent the fee from discriminating against independent pharmacies so as not to create a situation where state policies unintentionally diminish competition in the retail pharmacy business by establishing a fee that is adequate for chains but still insufficient for independent pharmacies.

▪ Medicaid Co-Pay

The Medicaid Co-Pay for prescription drugs has been set at $.50 per prescription. The budget act increased that amount to $2.00 per prescription. Federal rules provide that, if a state has a co-pay, it cannot become a barrier to access to needed medications for Medicaid recipients. Therefore, pharmacies are often unable to collect the co-pay and it becomes a cost to the pharmacy of doing business.

Testimony to the Committee on Health Care by the chain pharmacies indicated that approximately 35% of Medicaid recipients do not pay any co-pay. Independent

pharmacies stated that the percentage was higher for them and, that in the case of an independent pharmacy in Lawrence, the percentage who do not pay the co-pay was as high as 90%. All pharmacies expressed the concern that increasing the co-pay to $2.00 would increase the percentage of those who are unable to make a co-payment, and that loss would, under current policies, have to be absorbed by the pharmacy.

Senator Moore asked the Commissioner of Medical Assistance if the state considered two-tier co-pay rates with higher levels for brand name vs. generic drugs as five other states have done. The commissioner agreed that idea could have merit, but the concept had not be implemented because of administrative difficulties.

The Commissioner also noted that DMA had implemented a policy of requiring generic drugs unless prior approval is received for brand name drugs as a cost-saving measure. She also noted that DMA was reviewing data to determine which doctors tend to routinely issue prescriptions for brands as "medically necessary."

Representatives of Health Care for All expressed concern that a higher co-pay might discourage Medicaid recipients, especially those unaware of the federal rules prohibiting a required co-payment, from accessing needed medications.

> **<u>RECOMMENDATION #4:</u> The Medicaid Co-Pay rate should remain at $.50 per prescription.**

Senator Moore suggested that the Administration give consideration to a formula that would compensate pharmacies for the amount of co-payments that could not be collected because the recipients were unable to afford the co-payment and federal rules prohibited pharmacies from denying access to drugs to those unable to make a co-payment. It was subsequently learned from officials at the federal Centers for Medicare and Medicaid Services that there was no federal rule prohibiting such compensation. The rationale for such compensation is that: 1) society is responsible for caring for those who cannot afford to pay even the co-payment, and 2) federal rules prohibit denying access to the medications if there is a failure to make a co-payment.

> **<u>RECOMMENDATION #5:</u> The Swift Administration should calculate the average uncompensated co-pay and include that factor in setting the dispensing fee so that pharmacies are not required to absorb the full impact of uncompensated co-payments.**

▪ Non-Medicaid Prescription User Fee (Tax)

The budget provides that a user fee (or tax) also be calculated by the Administration and assessed on all non-Medicaid prescriptions. Although some budget analysts estimated that this fee would amount to $.60 per prescription, the Swift Administration has not yet calculated the precise fee. A review of practices among other states is that few impose a user fee and, those that do, set a fee of ten to fifteen cents. The Administration told the Committee on Health Care that this assessing this fee will not require a federal waiver, but will require submission of a plan amendment. However, a subsequent discussion with the federal Centers for Medicare

and Medicaid Services indicated that the Administration does need a waiver and, in fact, has submitted that request. It was noted that approval is not necessarily guaranteed.

Another issue in this area is that it appears that some health plan contracts prohibit pharmacies from charging any more than contracted amounts for prescriptions, other plans, and those without insurance do not prohibit such a practice. The result will be 1) an uneven application of the user fee, at least until new contracts are negotiated; and 2) a disproportionate burden on the non-Medicaid eligible uninsured – mostly seniors - who must pay cash for their prescriptions.

It appears likely that prescriptions purchased under the Massachusetts Prescription Advantage Program are subject to this user fee. If they are, this could increase the cost of the Prescription Advantage program as one state program imposes a charge on another state program although there is the potential for a federal match that would help the state to continue to afford the Prescription Advantage program.

RECOMMENDATION #6: The Administration should obtain more data on whether a user fee can be implemented fairly to all non-Medicaid prescriptions and, if possible, postpone the effective date to allow health plan contracts to be revised to accommodate the user fee concept.

RECOMMENDATION #7: If a user fee is deemed desirable, the amount should be limited to a rate more consistent with practices in other states.

▪ Access to Prescription Drugs

The major chain drug stores serving Massachusetts (CVS, Brooks, Walgreens) have publicly announced that they will no longer fill prescriptions for Massachusetts Medicaid recipients if the reimbursement rate, co-pay increase, and user fee are imposed as provided in the FY '03 General Appropriations Act.

According to testimony provided to the Committee on Health Care, the following is the distribution of types of pharmacies in Massachusetts:

CVS:.....299
Brooks:.....168
Walgreens: 86
Stop & Shop:.....75
Wal-Mart:.....38
Shaws: 22
Medicine Shoppe: 12
DAW Inc:.....11
Target: 11
Kmart: 7
FamilyMeds: 6
Louis & Clark Drug: 6
Costco: 5
Lincoln Discount:.....5

Big Y:.....4
A&P: 4
Hannaford Bros. Co.: 3
Price Chopper: 3
Independents: 236

Source: National Association of Chain Drug Stores. 7/1/02

The representatives of independent pharmacies in Massachusetts testified at the Committee on Health Care hearing that their economic position is even more tenuous since they do not have the resources enjoyed by the chain pharmacies or the general purpose stores with pharmacies. They suggest that they would be even more seriously damaged by the proposed changes in Medicaid prescription drugs regulations and would either have to decline to serve Medicaid recipients just as the chains have announced or they would be forced to close altogether. The loss of access to prescription drugs for Medicaid recipients either by the action of the chains or the independents or both would pose serious health risks for Medicaid recipients.

If the state moves ahead with its original plan and the chains pharmacies follow through on their threat to stop filling Medicaid prescriptions large areas of the Commonwealth where penetration of chain drug stores is limited will have serious access issues. It should be noted that Western Massachusetts, parts of Central Massachusetts, and some other regions have no public transportation to help Medicaid recipients gain access to pharmacies that might continue to fill Medicaid prescriptions.

If independent pharmacies are forced to curtail filling Medicaid prescriptions other populations will face an access issue. There are no chains in Martha's Vineyard and Nantucket and few in Western Massachusetts. If independents stop filling Medicaid prescriptions, these regions will witness major drug access issues.

The Administration suggested that mail order drug sales might be a means of serving Medicaid recipients unable to obtain drugs for local pharmacies. However, no information was provided to indicate that mail order pharmacies would accept the new Medicaid rates or co-pays any more readily than chain or independent retail pharmacies.

Furthermore, the Medicaid population may not respond well, with problems such as language barriers, to the use of mail order prescription program because it is more complicated than using local pharmacies. In addition, the Medicaid population tends to be more mobile making it more difficult to assure that recipients will still be living at the same address when the prescription arrives.

This issue needs to be determined before the state decides to call the "bluff" of the retail pharmacies.

There are also concerns about the efficacy and safety of reliance on mail order drug sales. In addition, there are currently no mail order pharmacies in doing business in Massachusetts. This means a loss of state tax revenues, loss of jobs for Massachusetts residents, and limitations on oversight of pharmacists practices by the

Board of Registration of Pharmacists. Mail order may be an acceptable option for those who prefer to do business that way, but it may not be satisfactory as the only means of obtaining prescriptions. Furthermore, to the degree that pharmacists have time to effectively counsel customers, that counseling opportunity is generally absent in mail order pharmacies.

Lack of access to prescription drugs for Medicaid recipients resulting from pharmacies declining to fill Medicaid prescriptions and higher co-pays that may discourage some individuals from presenting prescriptions to fill could, health systems pharmacists pointed out, since this population has high pharmaceutical needs, is likely to add to the burden of already overused hospital emergency departments and, in some cases, will increase use of the Uncompensated Care Pool. These would be additional negative consequences of any decrease in access to drugs for Medicaid recipients.

> **RECOMMENDATION #7: Since the loss of access or increased difficulty of access to pharmacy services for many of the state's Medicaid recipients could prove catastrophic, the Administration should develop a formula that will be sufficiently attractive to retain pharmacy participation at the most reasonable cost to taxpayers.**

▪ Variations in Impact on Pharmacy Types

Information presented to the Committee on Health Care revealed significant differences in how the proposed Medicaid prescription drug reimbursement rates and co-pays would impact on non-retail pharmacies - primarily health systems pharmacies serving hospitals and long term care pharmacies serving nursing homes.

Hospitals receive a favorable price from manufacturers and wholesalers because they strictly limit formularies and can force competing manufacturers to bid for their business. Unfortunately, a court decision that restricted hospitals to providing low cost drugs to their patients ONLY, prevents hospitals from extending their favorable pricing to anyone except legitimate patients. Higher co-pays for Medicaid recipients in hospitals will, in most cases be absorbed by the hospital because of the inability to collect from most patients. Lower Medicaid prescription reimbursements will add to the already difficult relationship between hospitals and Medicaid since hospital Medicaid reimbursement rates have been determined by an independent study commissioned by the Legislature to be about 71% of the cost of care.

Nursing homes are even more seriously impacted because of their very high ratio of Medicaid recipients and the admittedly low Medicaid reimbursement rates for nursing homes. In fact, the same budget that provides a mechanism of a nursing home user fee that is expected to result in approximately a 7.5% nursing home bed rate increase is likely to be eroded to some extent by the lower prescription drug reimbursement rate.

<u>RECOMMENDATION #8:</u> The Legislature should re-enact the Medicaid rate exemption that was included in the budget, but vetoed by the Governor, for long-term care pharmacies and for in-patient use of health-systems (hospital) pharmacies.

▪ Medical Errors

In written testimony provided to the Committee on Health Care by the Board of Registration in Pharmacy, among the points stressed were those of medical error reduction, patient safety, and health care quality. The Board stated: "Of additional concern to the Board is the need for Medicaid reimbursement rates to permit planned implementation of crucial and overdue systems improvements identified by the Board and many other groups as key to the detection and prevention of medication errors. In fact, the "Best Practices for the Prevention of Medication Errors" guide developed by the Board in 2001, advocates that pharmacies utilize and update as appropriate evolving technology specifically designed to assist pharmacists and pharmacy technicians in assuring that the correct patient gets the correct medication in the correct dosage. The use of enhanced computer technology, imaging and automation in contemporary pharmacy practice is both necessary and costly. Additionally, the Pharmacy Board is developing standards for the development and implementation of continuous quality improvement programs in pharmacies. In the opinion of the Board, achieving real improvements in medication delivery will only result from broad systems based on continual improvement focused initiatives and adequate resources to achieve these goals. Moreover, reimbursement rates must allow for progress in instituting long overdue pharmacy quality assurance programs."

Dr. Donald Berwick, a noted Boston-based expert in health care economics, has suggested that reduction of medical errors could reduce health costs by one-third. Since medication errors constitute the largest percentage of medical errors, instituting patient safety and medical quality assurance will reduce cost to the Medicaid and other insurance programs.

While Medicaid should not be expected to provide all the resources pharmacies need to improve safety and quality, Medicaid needs to support its fair share along with other third party payers. The poor and elderly residents of the Commonwealth are just as entitled to a safe medication system as those with greater ability to pay for these resources.

<u>RECOMMENDATION #9:</u> The Medicaid Pharmacy Reimbursement Rate needs to provide resources to encourage pharmacies to utilize the latest technology for promoting patient safety and medical quality.

Conclusion

▪ Recommendation summary

With public and private prescription drug benefit plans experiencing double-digit growth rates in total expenditures over the last several years, administrators have investigated and implemented various cost-containment strategies. In addition to cost-sharing, formularies, and plan limitations, the appropriateness of the pharmacy reimbursement mechanism is commonly reviewed. However, I would like to suggest several alternative suggestions that would maintain access for Medicaid members, fiscal strength for pharmacies and reduce some financial shortfalls for the state. Those recommendations are numbered below.

RECOMMENDATION #1: The Medicaid Pharmacy Reimbursement Rate should remain frozen at FY '02 rates until the federal government completes its review and reassessment of its report on pharmacy acquisition costs of prescription drugs. Upon release of the revised OIG report, the Swift Administration should establish a new pharmacy reimbursement rate for Medicaid prescriptions.

RECOMMENDATION #2: The Swift Administration, with support from Legislative Leaders, should directly, and through intervention of the Massachusetts Congressional Delegation, seek immediate release of the final OIG report.

RECOMMENDATION #3: Massachusetts should obtain accurate data to determine and establish a reasonable dispensing fee for Medicaid prescriptions.

RECOMMENDATION #4: The Medicaid Co-Pay rate should remain at $.50 per prescription.

RECOMMENDATION #5: The Swift Administration should calculate the average uncompensated co-pay and include that factor in setting the dispensing fee so that pharmacies are not required to absorb the full impact of uncompensated co-payments.

RECOMMENDATION #6: The Administration should obtain more data on whether a user fee can be implemented fairly to all non-Medicaid prescriptions and, if possible, postpone the effective date to allow health plan contracts to be revised to accommodate the user fee concept.

RECOMMENDATION #7: If a user fee is deemed desirable, the amount should be limited to a rate more consistent with practices in other states.

RECOMMENDATION #8: The Legislature should re-enact the Medicaid rate and co-pay exemption that was included in the budget, but vetoed by the Governor, for long-term care pharmacies as well as an exemption for health systems pharmacies serving in-patient Medicaid recipients.

RECOMMENDATION #9: The Medicaid Pharmacy Reimbursement Rate needs to provide resources to encourage pharmacies to utilize the latest technology for promoting patient safety and medical quality.

▪ Closing Statement

I recognize that some of the recommendations will pose financial problems for the Medicaid budget. Certainly, further reduction of benefits for Medicaid recipients is not the best way to pay for these changes from the budget plan.

One possible way to pay for the recommendations would be to seek a transfer from reserve accounts to cover the shortfall. Funds are available since the Governor vetoed approximately $300 million in the FY '03 budget that was not overridden. Of course, that means that less money will be available in reserves to off-set deficiencies during the year or to balance the FY '03 budget. It should be understood, however, that the savings expected from the reduction in Medicaid reimbursements will be a one-time savings. Once the rate is at or below cost, no further revenue is likely to be squeezed and would certainly exacerbate any access to medication problems that result from that rate reduction.

A more likely source of savings to off-set the cost of the recommendations is to more aggressively pursue the use of generic drugs whenever possible. While the Division of Medical Assistance has initiated efforts in this regard, it would appear that significantly more savings are possible to obtain. In the longer term, reduction of medical errors will provide savings to sustain the program.

I am willing to work with the Administration and to work with all parties to come to an equitable solution. I am prepared to continue this dialogue with other players, including the Pharmaceutical Manufacturers. We must all remember that information is vital to the success of the program. Legislators need information so we can review the methods and the approaches used in order to determine the best policy. If the state relies on flawed reports or absent information to make decisions regarding Medicaid payment rates, this could lead to serious repercussions for the state, pharmacies and ultimately the most vulnerable consumers.

I am committed to providing MassHealth members with access to quality prescription drug coverage that is affordable and suitable for today's health care needs.

Sincerely,

RICHARD T. MOORE
Senate Chair, Committee on Health Care